# Arkansas Department of Human Services
## Division of Medical Services
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**TO:** **Arkansas Medicaid Health Care Providers**

**DATE:** **August 1, 2003**

**SUBJECT:** **Section I Update Transmittal**

| Provider Manual | Transmittal Number |
|---|---|
| Alternatives for Adults with Physical Disabilities Waiver | 15 |
| Ambulatory Surgical Center | 46 |
| Certified Nurse-Midwife | 49 |
| Child Health Management Services | 48 |
| Child Health Services/Early and Periodic Screening, Diagnosis and Treatment | 52 |
| Children's Medical Services Respite Care | 1 |
| Children's Medical Services Targeted Case Management | 1 |
| Chiropractic | 45 |
| DDS Alternative Community Services Waiver | 40 |
| Dental | 64 |
| Developmental Day Treatment Clinic Services | 51 |
| Developmental Rehabilitation Services | 2 |
| Domiciliary Care | 32 |
| ElderChoices Home and Community-Based 2176 Waiver | 37 |
| Federally Qualified Health Center | 38 |
| Hearing Services | 41 |
| Home Health | 56 |
| Hospice | 32 |
| Hospital/End-Stage Renal Disease | 60 |
| Hyperalimentation | 54 |
| Inpatient Psychiatric Services for Under Age 21 | 47 |
| Licensed Mental Health Practitioners | 34 |
| Living Choices Assisted Living | 1 |
| Medicare/Medicaid Crossover Only | 28 |
| Nurse Practitioner | 42 |
| Occupational, Physical, Speech Therapy Services | 34 |
| Personal Care | 51 |
| Pharmacy | 61 |
| Physician/Independent Lab/CRNA/Radiation Therapy Center | 82 |
| Podiatrist | 41 |
| Portable X-Ray Services | 37 |

| Provider Manual | Transmittal Number |
|---|---|
| Private Duty Nursing Services | 46 |
| Prosthetics | 56 |
| Rehabilitative Hospital | 40 |
| Rehabilitative Services for Persons with Mental Illness | 44 |
| Rehabilitative Services for Persons with Physical Disabilities | 22 |
| Rehabilitative Services for Youth and Children | 3 |
| Rural Health Clinic Services | 37 |
| School-Based Mental Health Services | 7 |
| Targeted Case Management | 40 |
| Transportation | 56 |
| Ventilator Equipment | 40 |
| Visual Care | 52 |

| REMOVE | | INSERT | |
|---|---|---|---|
| **Page** | **Date** | **Page** | **Date** |
| Table of Contents | Dates Vary | Table of Contents | 8-1-03 |
| Pages I-59 through I-70 | Dates Vary | Pages I-59 through I-70 | 8-1-03 |

Explanation of Updates

**PLEASE NOTE:** A new numbering system is being initiated in sections 150 through 169. Six-digit section numbers are replacing the three and four digit numbers throughout the entire sections.

Page I-59, section 151.000, has been revised. Providers who are sanctioned must agree to mandatory attendance at provider education sessions, allow prepayment review of some or all of the provider's billings, and may be excluded under the Department of Human Services (DHS) Policy 1088, titled DHS Participant Exclusion Rule.

Pages I-60 through I-61, section 152.000, have been revised. Information has been updated regarding the grounds for sanctioning providers.

Page 1-61, section 153.000, has been included to advise that professional society, licensing, certifying or accrediting agency or entity will be notified of the findings made and sanctions imposed on a provider.

Page 1-62, section 154.000, has been included to advise of the changes in the imposition and scope of a sanction as defined in DHS Policy 1088, titled DHS Participant Exclusion Rule.

Explanation of Updates (Continued)

Page 1-63, section 160.000, has been included because the numbering and the title of the section have been revised. The title has changed from "Formal Hearings" to "Remedies for Non-Compliance."

Page I-63, section 161.000, has been included to explain the notification process involved when the Division of Medical Services identifies an act or omission for which a sanction may be issued.

Page I-63, section 161.100, has been re-titled "Withholding of Medicaid Payments." The section additionally notes that the Division of Medical Services may withhold Medicaid payment, without first notifying the provider, when reliable information is received that shows evidence of circumstances that involve fraud, willful misrepresentation or both. The section further covers the procedure involved to request a hearing and the circumstances involved that will end the withholding and payment action.

Page I-64, section 161.200, has been re-titled "Right to Informal Reconsideration" details the timeline involved in requesting an informal reconsideration and the designation on an individual by the Director of Medical Services to review the request and make a recommendation involving the appeal.

Page I-64, section 161.300, is a new section titled "Appeal." It details the deadline in which a provider may appeal an informal reconsideration decision that upholds an adverse action and advises the provider what information is needed for the appeal.

Page I-64, section 162.000, has been revised to change the title to "Notice of Appeal Hearing." The section has been reworded for ease of reference.

Page I-65, section 162.100, has been included to clarify information regarding the hearing officer's authority in providing for discovery and in accessing the expense of the requesting party and the provider's burden of proof in supplying evidence that it delivered all billed services as required.

Page I-66, section 162.200, is a new section titled "Representation of Provider at a Hearing". The section clarifies who may represent a provider, company or corporation. It also explains the conduct standards of those representatives at the hearing.

Page I-66, section 162.300, titled "Right to Counsel" explains that an attorney representing a provider must conform to the standards of conduct as practiced before the courts of Arkansas.

Pages I-66 through I-68, sections 162.400 thorough 166.000, have been included because sections have been renumbered. Some text changes have been made in the sections for clarity.

Page I-68, section 167.000, has been revised. Policy has been clarified by stating that if a party fails to appear at a hearing, the hearing officer may dismiss the appeal or make an adverse determination against the non-appearing party. Obsolete information has been removed from the section.

Page I-68, section 168.000, has been included to advise that hearings must be tape-recorded. If the agency decision is appealed, the tape recording will be transcribed and copies of other evidence must be reproduced for filing under the Administrative Procedures Act (APA).

Explanation of Updates (Continued)

Page I-69, section 169.000, has been revised to clarify that a hearing officer, at the conclusion of a hearing, will present a proposed decision to the Director. The decision will be in writing and will contain findings, facts, conclusions of law and a proposed order. After review, the Director's decision is the final agency determination under APA regulations.

Page I-69A is included to add Form DMS-635, titled Notice of Non-Compliance.

Page I-70, section 170, is included because of repagination.

A change bar in the left margin denotes a revision.

Attached are updated pages to file in your provider manual.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

**If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.**

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Interim Director

*Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website:* **www.medicaid.state.ar.us**.

| Arkansas Medicaid Manual: | Page: |
|---|---|
| | Effective Date: 1-1-86 |
| Subject: TABLE OF CONTENTS | Revised Date: 3-1-02 |

## 150.000 ADMINISTRATIVE REMEDIES AND SANCTIONS

### 151.000 Sanctions

The following sanctions may be invoked against providers based on the grounds specified in the following sections:

A. Termination from participation in the Medicaid Program;

B. Suspension of participation in the Medicaid Program;

C. Suspension, withholding recoupment, recovery or any combination thereof of payments to a provider;

D. Cancellation of the provider agreement or shortening of an already existing provider agreement;

E. Mandatory attendance at provider education sessions;

F. Imposition of prior authorization of services;

G. Prepayment review of some or all of the provider's billings;

H. Referral to the State Licensing Board for investigation;

I. Referral to the Fraud Investigation Unit;

J. Transfer to a closed-end provider agreement not to exceed 12 months;

K. Referral to appropriate federal or state legal agency for prosecution under applicable federal or state laws;

L. Referral to the appropriate state professional health care association’s peer review mechanism;

M. Exclusion under Department of Human Services (DHS) Policy 1088, titled DHS Participant Exclusion Rule;

152.000 Grounds for Sanctioning Providers

Sanctions may be imposed against a provider for any one or more of the following reasons:

A. Presenting or causing to be presented for payment any claim for care, services or merchandise that fails to accurately represent the care, services or merchandise provided.

B. Submitting or causing to be submitted information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charging Medicaid patients more than other patients receiving the same service.

C. Submitting, or causing to be submitted, inaccurate or misstated information in connection with utilization, controls, including prior authorization requirements.

D. Failing to disclose or make available, upon request, to the Division of Medical Services or its authorized representative, State Medicaid Fraud Control Unit and representatives of the Department of Human Services all records relating to any Medicaid recipient and records of payments made.

E. Failing to provide and maintain quality services, within accepted medical community standards as adjudged by a body of peers.

F. Any act or omission that is abusive to the Medicaid Program.

G. Breaching the terms of the Medicaid provider agreement or failing to comply with the certification standards or with the terms of the provider certification.

H. Inducing, furnishing, arranging, referring or otherwise causing a recipient to receive tests, examinations, service(s) or merchandise that is not medically necessary.

I. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

J. Violating any state or federal provision of the Title XIX Program or any rule or regulation pertaining to Title XIX.

K. Submitting a false application for provider status.

L. Violating any laws, regulations or Code of Ethics governing the conduct of occupations or professions or regulated industries.

M. Accepting patients for whom all required care and services cannot be provided.

152.000 Grounds for Sanctioning Providers (Continued)

N. Being convicted of a civil or criminal offense relating to performance of a provider agreement or failure to comply with the applicable standard of care.

O. Failure to meet standards required by state or federal law for Medicaid participation including licensure.

P. Exclusion from Medicare.

Q. Failure to accept Medicaid payment as payment in full for covered services.

R. Refusal to execute a new provider agreement when requested to do so.

S. Failure to correct deficiencies after receiving written notice of deficiencies from the Division of Medical Services or the licensing or certifying entity.

T. Formal reprimand or censure by a licensing, certifying or accrediting agency or entity.

U. Suspension, debarment, exclusion or termination from participation in another governmental program.

V. Failure to pay or make arrangements acceptable to the state for the repayment of any funds due to the state.

W. Billing the state Medicaid Program for services before providing those services.

X. Any act or omission that subjects a provider to exclusion under DHS Policy 1088, titled DHS Participant Exclusion Rule.

Y. Any act or omission that violates a provision of any applicable Medicaid provider manual.

153.000 Notice of Sanction

A. When a provider has been sanctioned, the Department of Human Services shall notify the applicable professional society, and any licensing, certifying or accrediting agency or entity of the findings made and the sanctions imposed.

B. Where a provider's participation in the Medicaid Program has been suspended or terminated, the Department of Human Services will notify the recipients for whom the provider claims payment for services that such provider has been suspended or terminated. Such notice may include the reason for suspension or termination.

154.000 Rules Governing the Imposition and Extent of Sanction

A. Imposition of a Sanction

1. The Director of the Division of Medical Services shall determine the sanction to be imposed as provided in paragraph A.3.

2. The following factors shall be considered in determining the sanction(s) to be imposed:

   a. Seriousness of the offense(s);

   b. Extent of violation(s);

   c. History of prior violation(s);

   d. Whether an indictment or information was filed against the provider or a related party as defined in DHS Policy 1088 titled DHS Participant Exclusion Rule.

3. Whenever a provider is convicted of any Medicaid Program violation, or is suspended or terminated from the Medicare Program for cause, the Department of Human Services shall institute proceedings to terminate the provider from the Medicaid Program.

B. Scope of Sanction

1. A sanction applies to all related parties as defined in DHS Policy 1088,

2. Suspension or termination from participation of any provider shall preclude such provider from submitting claims for payment, either personally or through claims submitted by a clinic, group, corporation or other association to DHS for any services or supplies provided after the suspension or termination.

3. No provider shall submit claims for payment for any goods or services provided by a person who has been debarred, excluded, suspended or terminated from participation in the Medicaid Program except for those services or supplies provided before the suspension or termination.

4. Any provider violating provisions of paragraph B.3, along with the provider's related parties, as defined in DHS Policy 1088, shall be suspended, terminated, or excluded from participation.

160.000 REMEDIES FOR NON-COMPLIANCE

161.000 Notice of Violation

If the Division of Medical Services identifies an act or omission for which a sanction may be issued, the Division will notify the provider of the act or omission. The notification will be in writing and will set forth:

A. The nature of the act or omission;

B. The amount of any overpayment, recoupment or recovery, if known;

C. The method of computing such amount;

D. The sanction or sanctions to be imposed;

E. Notification of any actions required of the provider and the provider's right to appeal.

161.100 Withholding of Medicaid Payments

The Division of Medical Services may withhold Medicaid payments, in whole or in part, to a provider upon receipt of reliable evidence that circumstances involve fraud, willful misrepresentation or both.

The Division of Medical Services may withhold payments without first notifying the provider of its intention to withhold.

The provider may request, and will be granted, administrative review. See section 161.200.

Within five days of taking the action, the Division of Medical Services will send the Notice of Non-Compliance (Form DMS-635) that explains the reasons for withholding payment and the provider's right for administrative review.

All withholdings or payment actions will be temporary and will not continue after:

A. The Division of Medical Services or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation, or

B. Legal proceedings relating to the provider's alleged fraud or willful misrepresentations are completed.

161.200 Right to Informal Reconsideration

Within 10 calendar days after notice of adverse action, the provider may request an informal reconsideration. Requests must be in writing. Within 20 calendar days after the request, the provider must submit, in writing, all alleged facts (including supporting documentation, and legal arguments that the provider asserts in opposition to the adverse action. Informal reconsideration does not postpone any adverse action that may be imposed pending appeal.

Unless a timely and complete request for informal reconsideration or appeal is received by the Department of Human Services, the findings of DHS shall be considered a final and binding administrative determination.

Within 20 days of receiving a timely and complete request for informal reconsideration, the Director of the Division of Medical Services will designate an individual who did not participate in the determination leading to the adverse action who is knowledgeable in the subject matter of the informal reconsideration to review the informal reconsideration request and associated documents. The reviewer shall recommend to the Director that the adverse action be sustained, reversed, or modified. The Director may adopt or reject the recommendation in whole or in part.

No informal reconsideration or appeal is allowed if the adverse action is due to loss of licensure, accreditation or certification.

161.300 Appeal

Within 20 days of receiving notice of adverse action, or 10 days of receiving an informal reconsideration decision that upholds all or part of any adverse action, whichever is later, the provider may appeal. Each notice of appeal must be in writing and state with particularity all findings, determinations, and adverse actions that the provider alleges are not supported by the facts or the applicable laws (including state and federal laws and rules, and applicable professional standards) or both. Within 20 days of receiving a notice of appeal the Director of the Division of Medical Services shall designate a hearing officer and set a date for the formal hearing.

162.000 Notice of Appeal Hearing

When an appeal hearing is scheduled, the Division of Medical Services shall notify the provider or, if the provider is represented by an attorney, the provider's attorney, in writing of the date, time and place of the hearing. Notice shall be mailed not less than 10 calendar days before the scheduled date of the hearing.

162.100 Conduct of Hearing

A. The hearing shall be conducted by a hearing officer who is authorized by the Director of the Division of Medical Services to conduct such hearings.

B. Testimony shall be taken only under oath, affirmation or penalty of perjury.

C. Each party shall have the right to call and examine parties and witnesses, to introduce exhibits, to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination. Each party has the right to impeach any witness regardless of which party first called him to testify. Each party has the right to rebut the opposing evidence.

D. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil or criminal actions.

E. The hearing officer may provide for discovery by any means permitted by the Arkansas Rules of Civil Procedure and may assess the expense to the requesting party.

F. The hearing officer may question any party or witness and may admit any relevant and material evidence.

G. The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Before taking evidence, the hearing officer shall explain the issues and the order in which evidence will be received.

H. The provider shall have the burden of proving by a preponderance of the evidence that it delivered all billed services in conformity with all applicable requirements.

I. Except as provided in H., the burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

162.200 Representation of Provider at a Hearing

Individual providers may represent themselves. A partner may represent the partnership. A limited liability company or corporation may be represented by an officer or the chief operating official. A professional association may be represented by a principal of the association. Representatives must be courteous in all activities undertaken in connection with the appeal, and must obey the orders of the hearing officer regarding the presentation of the appeal. Failure to do so may result in exclusion from the appeal hearing, or the entry of an order denying discovery.

162.300 Right to Counsel

Any party may appear and be heard at any proceeding described herein through an attorney-at-law. All attorneys shall conform to the standards of conduct practiced by attorneys before the courts of Arkansas. If an attorney does not conform to those standards, the hearing officer may exclude the attorney from the proceeding.

162.400 Appearance in Representative Capacity

A person appearing in a representative capacity shall file a written notice of appearance on behalf of a provider identifying himself by name, address and telephone number; identifying the party represented and shall have a written authorization to appear on behalf of the provider. The Department of Human Services shall notify the provider in writing of the name and telephone number of its representative.

163.000 Form of Papers

All papers filed in any proceeding shall be typewritten on legal sized white paper using one side of the paper only. They shall bear a caption clearly showing the title of the proceeding in connection with which they are filed together with the docket number, if any.

The party, his authorized representative or attorney shall sign all papers, and all papers shall contain his address and telephone number. At least an original and two copies of all papers shall be filed with the Division of Medical Services.

163.100 Notice, Service and Proof of Service

A. All papers, notices and other documents shall be served by the party filing same upon all parties to the proceeding. Proof of such service upon all parties shall be filed with the Division of Medical Services.

B. Service shall be made by delivering, in person or by mail, properly addressed with postage prepaid, one copy to each party entitled thereto. When any party or parties have appeared by attorney, service upon the attorney shall be deemed service upon the party or parties.

C. Proof of service of any paper shall be by certificate of attorney, affidavit or acknowledgement.

D. Wherever notice or notification by the Division of Medical Services is indicated or required, notification shall be effective upon the date of first class mailing to a provider's or other party's business address or residence.

E. In addition to the methods provided for in these regulations, a provider may be served in any manner permitted by law.

164.000 Witnesses

A party shall arrange for the presence of his witnesses at the hearing.

165.000 Amendments

At any time prior to the completion of the hearing, amendments to the adverse action, the provider's notice of appeal, or both, may be allowed on just and reasonable terms to add any party who ought to have been joined, discontinued as to any party, change the allegations or defenses or add new causes of action of defenses. Where the Division of Medical Services seeks to add a party or a cause of action or change an allegation, notice shall be given pursuant to section 161.000, "Notice of Violation", and section 163.100, "Notice, Service and Proof of Service", to the appropriate parties except that the provisions of section 161.200, "Right to Informal Reconsideration", and section 162.000, "Notice of Appeal Hearing", shall not apply. Where a party other than the Division of Medical Services seeks to add a party or change a defense, notice shall be given pursuant to section 163.100, "Notice, Service and Proof of Service". The hearing officer shall continue the hearing for such time as he deems appropriate, and notice of the new date shall be given pursuant to section 166.000, "Continuances or Further Hearings".

166.000 Continuances or Further Hearings

A. The hearing officer may continue a hearing to another time or place or order a further hearing on his own motion or upon showing of good cause at the request of any party.

B. Where the hearing officer determines that additional evidence is necessary for the proper determination of the case, he may, at his discretion:

1. Continue the hearing to a later date and order the party to produce additional evidence; or

2. Conclude the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties, and each party shall have the opportunity for rebuttal.

C. Written notice of the time and place of a continued or further hearing shall be given, except that when a continuance or further hearing is ordered following a hearing, oral notice of the time and place of the hearing may be given to each party present at the hearing.

167.000 Failure to Appear

If a party fails to appear at a hearing, the hearing officer may dismiss the appeal or enter a determination adverse to the non-appearing party. A copy of the decision shall be mailed to each party together with a statement of the provider's right to reopen the hearing.

168.000 Record of Hearing

The Division of Medical Services (DMS) shall tape record the hearings, or cause the hearings to be tape-recorded. If the final DMS determination is appealed, the tape recording shall be transcribed and copies of other documentary evidence shall be reproduced for filing under the Administrative Procedures Act.

169.000 Decision

A. At the conclusion of the hearing, the hearing officer shall take the matter under consideration and shall submit a proposed decision to the Director of the Division of Medical Services.

B. The proposed decision shall be in writing and shall contain findings of fact, conclusions of law and a proposed order.

C. The Director may adopt the proposed decision, or he may reject the proposed decision and have a decision prepared based upon the record, or he may remand the matter to the hearing officer to take additional evidence. In the latter case, the hearing officer, thereafter, shall submit to the Director a new proposed decision.

The Director's decision is the final agency determination under the Administrative Procedures Act. The Director shall cause a copy of the decision to be mailed to the provider at the provider's last known address, or, if the provider was represented by an attorney, to the address provided by the attorney.

# ARKANSAS DEPARTMENT OF HUMAN SERVICES
# DIVISION OF MEDICAL SERVICES

## NOTICE OF NONCOMPLIANCE

This is to advise you of the results of: ☐ an investigation, ☐ a review, or ☐ an audit concerning the following services billed to the Medicaid Program:

_____

The Division of Medical Services has determined that:

_____

_____

_____

_____

_____

_____

The Division of Medical Services has determined that the acts, omissions, or both described in paragraph two violate the following Medicaid requirements:

_____

_____

(Include citation to relevant sections of Title XIX, the appropriate C.F.R., applicable state laws and the provider manual.)

Based on these determinations, the Division of Medical Services is imposing the following remedies, sanctions, or both, effective _____.

Imposition of remedies, sanctions, or both is based on:

_____

_____

(Cite the relevant sections of the provider manual).

In addition, there is reliable evidence that the acts, omissions, or both, described in paragraph two involve fraud, willful misrepresentation, or both. Accordingly, effective _____, the Division of Medical Services is withholding Medicaid provider payments as authorized by 42 C.F.R. § 455.23.

Withholding is temporary, and will end when: (a) the Division of Medical Services or the prosecuting authorities determine that there is insufficient evidence of fraud or willful misrepresentation; or (b) legal proceedings regarding the issues raised in this notice are complete.

**If you disagree with one or more of these determinations, or the imposition of sanctions or payment withholding, you may:**

**Request an informal reconsideration** by submitting written information and documentation to refute the determination(s). All requests must be received within ten (10) days of the date of this letter. You must submit documents and written arguments supporting the informal reconsideration within twenty days of the request. Your submissions will be reviewed and a reconsideration decision issued in accordance with the informal reconsideration provisions in your provider manual.

**Request a formal appeal** in accordance with the appeal provisions in your provider manual. A notice of appeal must be received within twenty days after the date of this notice, or ten days after an informal reconsideration decision that upholds all or part of any remedy, sanction, or determination of fraud or willful misrepresentation.

If you choose not to contest the determinations in this notice, you must immediately comply with any remedy or sanction. If the remedy or sanction includes repayment, please forward a check for the amount determined. Your check must be made payable to the Arkansas Division of Medical Services, with your provider identification number indicated on the face of the check, and mailed, along with a copy of this notice, to:

Arkansas Department of Human Services
Accounts Receivable Unit
P.O. Box 1437, Slot WG2
Little Rock, Arkansas 72203

**Do not remit to Electronic Data Systems.**

**Notice:**

**The recipient may not be held liable for a claim or portion of a claim for services denied due to provider error or upon a determination by the Division of Medical Services or its contractors that the services were not medically necessary.**

**Remedies imposed under this notice do not preclude the imposition of additional remedies, including criminal penalties, which may be available under state and federal laws and rules.**

170 ADVANCE DIRECTIVES

On December 1, 1991, the requirements for advance directives in the Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act 1990, P.L. 101-508 took effect. As of December 1, 1991, Medicaid certified hospitals and other health care providers and organizations are required to give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. This legislation does not require individuals to execute advance directives.

Medicaid certified hospitals, nursing facilities, hospices, home health agencies and personal care agencies must conform to the requirements imposed by the Health Care Financing Administration. The federal requirements mandate conformity to current State law. Accordingly, providers must:

* Provide all adult patients (not just Medicaid patients) with written information about their rights under State law to make health care decisions, including the right to accept or refuse medical or surgical treatment and the right to execute advance directives. This information must be provided:

  1. by hospitals at the time of the individual's admission as an inpatient,

  2. by nursing facilities:
     a. when the individual is admitted as a resident or
     b. to existing residents no later than the second quarterly review of care occurring after December 1, 1991,

  3. by a provider of home health or personal care services in advance of the individual receiving care and

  4. by hospices at the time of initial receipt of hospice care.

* Maintain written policies, procedures and materials concerning advance directives to ensure compliance with the law.

* Inform all patients and residents about the provider's policy on implementing advance directives.

* Document in each patient's medical record whether the patient has received information regarding advance directives. Providers must also document whether patients have signed an advance directive and must record the terms of the advance directive.